STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175418	A. BUILDING _____ B. WING _____	C 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE LIVING CENTER	**1112 SE REPUBLICAN TOPEKA, KS 66607**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #88872 and 90323.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 77 residents. The sampled included 3 residents. Based on observation, interview, and record review, the facility failed to report to the state agency allegations of resident-to-resident sexual abuse for 2 of 3 residents sampled, #1, and #2.

Findings included:

- Review of a nursing note dated 6/30/15 at 10:09 A.M. documented that an unidentified resident and facility staff reported resident #1 twisted a [gender] resident ' s chest area the previous evening.

Social services note dated 7/1/15 at 11:26 A.M. documented on 6/30/15 resident #4 reported to staff while on the smoking patio, resident #1 touched his/her chest area.

Observation on 9/29/15 at 11:45 A.M. revealed the resident sat quietly at the dining table conversing with 5 other unsampled residents.

The facility report documented the allegation of resident-to-resident sexual abuse on 6/30/15 and reported the allegation on 7/6/15 (6 days after the allegation).

During an interview on 9/29/15 at 8:30 A.M. administrative nursing staff D revealed the administrator or director of nursing notified the

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F 225	Continued From page 2	F 225		

state agency with resident-to-resident abuse.

On 9/29/15 at 11:30 A.M. licensed nursing staff G revealed staff notified resident-to-resident altercations with the on-call social worker and either the director of nursing or the administrator was responsible to notifying the state agency.

Either on 9/29/15 at 3:00 P.M. administrative nursing staff E revealed the director of nursing or the administrator notified the state agency of resident-to-resident altercations.

Review of the facility provided undated Abuse, Neglect, Exploitation (ANE) policy directed the purpose of the policy was to ensure all alleged violations of the Federal or State law was involving that mistreatment or abuse were reported immediately to the facility Administrator and to appropriate state agencies in accordance with the existing state law. Any staff member who suspected an alleged violation would notify the Administrator, director of nursing, on-call social worker or their designees immediately. The administrator or designee would notify the state agency within 24 hours.

The facility failed to timely report an allegation of resident-to-resident sexual abuse to the state agency as required by the state regulations.

- Review of nursing notes dated 8/8/15 at 11:51 A.M. documented the resident #2 reported his/her roommate had disrespected him/her, called 911 on the facility pay phone at approximately 6:45 A.M., and reported he/she had been raped.

Nursing note dated 8/10/15 at 5:37 A.M. recorded the resident came out of his/her room and

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F 225	Continued From page 3	F 225		

reported to staff, his/her roommate was nasty and trying to get in bed with me naked and run on me.

Nursing note dated 8/10/15 at 10:44 A.M. documented nursing staff called the social services staff on 8/8/15 at 6:35 A.M. and reported the alleged rape of the resident by his/her roommate. The resident did not want to file a report however, stated the roommate was naked on top of him/her.

Observation on 9/15/15 at 9:20 A.M. revealed resident #2 quietly attended a group activity with 6 other unsampled residents in the dining room.

A statement by licensed nursing staff H dated 8/10/15, documented the resident reported sexual abuse by his/her roommate on 8/8/15.

The facility report documented the allegation of resident-to-resident sexual abuse on 8/8/15 and reported the allegation on 8/11/15, (3-days after the allegation).

During an interview on 9/29/15 at 8:30 A.M. administrative nursing staff D revealed the administrator or director of nursing notified the state agency with resident-to-resident abuse.

On 9/29/15 at 11:30 A.M. licensed nursing staff G revealed staff notified resident-to-resident altercations with the on-call social worker and either the director of nursing or the administrator was responsible to notifying the state agency.

Either on 9/29/15 at 3:00 P.M. administrative nursing staff E revealed the director of nursing or the administrator notified the state agency of resident-to-resident altercations.

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F 225	Continued From page 4 Review of the facility provided undated Abuse, Neglect, Exploitation (ANE) policy directed the purpose of the policy was to ensure all alleged violations of the Federal or State law was involving that mistreatment or abuse were reported immediately to the facility Administrator and to appropriate state agencies in accordance with the existing state law. Any staff member, who suspected an alleged violation, would notify the Administrator, director of nursing, on-call social worker or their designees immediately. The administrator or designee would notify the state agency within 24 hours. The facility failed to timely report an allegation of resident-to-resident sexual abuse to the state agency as required by the state regulations.	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility identified a census of 77 residents. Based on interview and record review, the facility failed to incorporate the 6/17/11 Centers for Medicare and Medicaid Services (CMS) letter entitled " Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act, into the existing facility policy.	F 226		

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F 226	Continued From page 5	F 226		

Findings included:

- The facility provided undated policy titled Abuse, Neglect, and Exploitation, lacked information regarding reporting of suspicion of crimes by a covered individual to at least one law enforcement agency, a 2-hour reporting limit to law enforcement and state survey agency by a covered individual on a suspicion of serious bodily injury and for all others within 24 hours. The facility policy did not include that the facility would notify covered individuals annual of their reporting obligations, to prevent retaliation if an employee made a report, and post information about employee rights, including the right to file a complaint if a long-term care facility retaliated against anyone who filed a report.

During an interview on 9/29/15 at 2:30 P.M. social services staff X reported he/she was unaware of the CMS information on reporting reasonable suspicion of a crime.

During an interview on 9/29/15 at 3:00 P.M., licensed nursing staff E revealed the director of nursing or the administrator notified the state agency of any allegations of sexual abuse and was unaware of the CMS information on reporting reasonable suspicion of a crime.

The facility failed to fully develop written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.